

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

*Poc accepted*

PRINTED: 09/09/2005  
FORM APPROVED  
7/23/05 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  295079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/16/2005
NAME OF PROVIDER OR SUPPLIER  EVERGREEN MOUNTAINVIEW HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 201 KOONTZ LANE CARSON CITY, NV 89701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  This Statement of Deficiencies was generated as the result of a complaint investigation conducted at your facility on 8/16/05.  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.  Complaint #NV00009163 alleged that due to the lack of supervision the facility failed to prevent a resident residing on the locked unit from eloping out into the community and, as a result, the resident did not receive his medications as prescribed by the physician.  The investigation determined that the allegation was substantiated. A deficiency was cited at Tag F 324.	F 000	<b>DISCLAIMER CLAUSE</b> PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.		
F 324 SS=D	483.25(h)(2) ACCIDENTS  The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide adequate supervision to prevent a resident from eloping from the facility grounds and, as a result, did not receive his prescribed medications.	F 324	Resident #1 was last seen in the Dining Room at 9:00am. The nurse became aware of his absence at approximately 9:45am, when the nurse went to administer his medication. A search of the facility was conducted, then the parameter of the building was searched for the resident, per company policy. Approximately one hour later, the police were called. Resident #1 was placed on 15 minute checks upon his return to the facility for 72 hours. All of the windows on the Alzheimer's unit were repaired with a non-slotted hex screw that requires a special tool to unscrew, preventing the windows from opening more than a few inches. Resident #1 has not been out on pass with his wife since this occurred. All residents have the potential to be affected.		RECEIVED SEP 22 2005 BUREAU OF LICENSURE AND REGISTRATION CARSON CITY, NEVADA 8-17-05 8-17-05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

RON PETERSEN  
ADMINISTRATOR

(X6) DATE

9-22-05

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 324	Continued From page 1  Findings include:  Resident #1: This 57 year old male resident was admitted to the facility on 6/10/2005, with diagnoses that included anoxic brain damage, old myocardial infarction, hypothyroidism, and hypertension. The resident had a cardiac pacemaker. The resident was admitted to the locked Alzheimer unit because of an elopement risk.  A review of the facility's internal investigative notes revealed that the resident's location was first in question after a staff nurse reported the resident missing at 9:45 AM on 8/15/05. The nurse first noted the resident missing because Resident #1 was not available for his medications at approximately 9:00 AM. The nurse on duty informed the social services department at 10:00 AM. Not until 10:45 AM on 8/15/05, was the sheriff's department notified that the staff last observed the resident at 9:00 AM. Staff interviews and reviews of all of the facility's documentation revealed that approximately two hours elapsed before the facility was actually aware that the sheriff's department had responded to the report of the resident in a nearby housing tract knocking on a stranger's door. When the sheriff's department found the resident he was lying outside in a yard. Emergency staff responded and transferred the resident to the local emergency room (ER). The resident was administered Narcan 2 mg IV. The resident was described as having slurred speech by the ER staff. The resident's wife was notified by the ER of his admission, she went to the emergency room, and took the resident back to the facility.	F 324	Monthly checking security of the windows will be added to the preventative maintenance program. The Maintenance Director will be responsible for maintaining and updating the log. Prevention of elopements will provide opportunity for medications to be given according to standards of practice. 15 minute checks will be initiated on resident #1 for 48 hours upon return from any outings from the facility. Any and all elopements will be recorded on an event report and reviewed weekly in the high risk meeting with the Interdisciplinary team. The Alzheimer's Program Director will be responsible for compliance of the corrective action. The Director of Nursing will monitor for ongoing compliance. All measures will be put in place by no later than October 1, 2005.		10-1-05

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F 324	Continued From page 2  Interviews with the nursing staff and record review revealed that due to Resident #1's elopement the medications normally administered between 8:00 AM and 9:00 AM were not given as prescribed.  A review of the facility's internal investigation revealed that Resident #1 eloped through a window that was locked shut by a make shift screw device. Interviews with the administrator and record review revealed that the screw was missing and that this enabled the resident to open the bedroom window to the outside, climb through and leave without being seen by staff.  Interviews with social services staff revealed that, when the resident went home to visit with his family that he was more likely to attempt eloping. The resident had gone home for a visit three days prior to the event. After the incident, the resident's care plan was updated to implement 15 minute checks for 72 hours after every home visit.  The facility failed to provide adequate supervision and monitoring until after the resident eloped and was found lying on the ground outside of the facility's protective environment. The resident was also not given medications as scheduled.	F 324			

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